Senate

General Assembly

File No. 17

February Session, 2012

Substitute Senate Bill No. 97

Senate, March 8, 2012

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING BREAST CANCER SCREENING.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-503 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2013*):

(a) (1) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for mammographic examinations to any woman covered under the policy **[**which**]** that are at least equal to the following minimum requirements: (A) A baseline mammogram for any woman who is thirty-five to thirty-nine years of age, inclusive; and (B) a mammogram every year for any woman who is forty years of age or older.

(2) Such policy shall: **[**provide**]**

(A) Provide additional benefits for [: (A) Comprehensive] (i) comprehensive ultrasound screening [and magnetic resonance imaging] of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's physician or advanced practice registered nurse, [;] and [(B) Magnetic] (ii) magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society; [or the American College of Radiology.] and

(B) Not impose a coinsurance, copayment, deductible or other out-of-pocket expense for such ultrasound screening, except that a high deductible health plan, as that term is used in subsection (f) of section 38a-493, shall not be subject to this subparagraph.

(b) [Benefits] Except as specified in subparagraph (B) of subdivision (2) of subsection (a) of this section, benefits under this section shall be subject to any policy provisions that apply to other services covered by such policy.

(c) [On and after October 1, 2009, each] Each mammography report provided to a patient shall include information about breast density, based on the Breast Imaging Reporting and Data System established by the American College of Radiology. Where applicable, such report shall include the following notice: "If your mammogram demonstrates that you have dense breast tissue, which could hide small abnormalities, you might benefit from supplementary screening tests, which can include a breast ultrasound screening or a breast MRI examination, or both, depending on your individual risk factors. A report of your mammography results, which contains information about your breast density, has been sent to your physician's office and you should contact your physician if you have any questions or concerns about this report.".

Sec. 2. Section 38a-530 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2013*):

(a) (1) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for mammographic examinations to any woman covered under the policy **[**which**]** that are at least equal to the following minimum requirements: (A) A baseline mammogram for any woman who is thirty-five to thirty-nine years of age, inclusive; and (B) a mammogram every year for any woman who is forty years of age or older.

(2) Such policy shall: **[**provide**]**

(A) Provide additional benefits for **[**: (A) Comprehensive**]** (i) comprehensive ultrasound screening **[**and magnetic resonance imaging**]** of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's physician or advanced practice registered nurse, **[**;**]** and **[**(B) Magnetic**]** (ii) magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society; **[**or the American College of Radiology.**]** and

(B) Not impose a coinsurance, copayment, deductible or other out-of-pocket expense for such ultrasound screening, except that a high deductible health plan, as that term is used in subsection (f) of section 38a-520, shall not be subject to this subparagraph.

(b) **[**Benefits**]** Except as specified in subparagraph (B) of subdivision (2) of subsection (a) of this section, benefits under this section shall be subject to any policy provisions that apply to other services covered by

such policy.

(c) **[**On and after October 1, 2009, each**]** Each mammography report provided to a patient shall include information about breast density, based on the Breast Imaging Reporting and Data System established by the American College of Radiology. Where applicable, such report shall include the following notice: "If your mammogram demonstrates that you have dense breast tissue, which could hide small abnormalities, you might benefit from supplementary screening tests, which can include a breast ultrasound screening or a breast MRI examination, or both, depending on your individual risk factors. A report of your mammography results, which contains information about your breast density, has been sent to your physician's office and you should contact your physician if you have any questions or concerns about this report.".

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2013*	38a-503
Sec. 2	*January 1, 2013*	38a-530

INS *Joint Favorable Subst.*

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 13 $	FY 14 $
State Comptroller - Fringe Benefits	GF & TF - Cost	Less than $5,000	Less than $10,000

Note: GF=General Fund, TF = Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 13 $	FY 14 $
Various Municipalities	STATE MANDATE - Cost	Potential	Potential

Explanation

There may be a potential cost of less than $5,000 in FY 13 and less than $10,000 in FY 14 to the state as a result of eliminating out-of-pocket expenses, including copayments and deductibles, for breast ultrasound screenings[1]. The increased cost is attributable to covering 100% of costs for out-of network breast ultrasound screenings for those individuals enrolled in the state Point of Service (POS) plans, who fit the parameters set forth in the bill. The state currently covers 80% of allowable costs for services rendered by an out-of-network provider; the member is responsible for the balance[2]. The state plan does not require any cost sharing for in-network screenings. The vast majority of plan members use in-network services. The cost would depend on the number of individuals enrolled in the POS who receive the service

[1] FY 13 reflects a partial year of expenses and assumes the state plan adopts the mandate effective January 1, 2013. If the state were to adopt the mandate at the beginning of the next plan year, July 1, 2014, there would be no cost in FY 13.
[2] *Source*: State of Connecticut Health Benefit Plan: Plan Document.

from out-of-network providers[3].

The State Employees' Health plan is currently self-insured. Pursuant to current federal law, self-insured health plans are exempt from state health mandates, however in previous self funded arrangements the state has traditionally adopted all state mandates. To the extent the state continues this practice of voluntary mandate adoption, the aforementioned impacts are anticipated.

The bill's elimination of cost-sharing for breast ultrasound screenings may increase costs to certain fully insured municipal plans which require member cost sharing for breast ultrasound screenings. The coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2013[4]. Due to current federal law, municipalities with self-insured plans are exempt from state health insurance mandates.

Many municipal health plans are recognized as "grandfathered" health plans under the Patient Protection and Affordable Care Act (PPACA)[5]. It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under PPACA[6].

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[3] The potential cost assumes the average ultrasound screening is approximately $220. (*Source*: University of Connecticut. *Review and Evaluation of Certain Health Benefit Mandates in Connecticut*, 2012, p. 198)

[4] It is estimated the removal of cost sharing requirements for breast ultrasound screenings increase premiums (medical and administrative costs) by $0.24 per member per month (PMPM) 2013 and $0.26 PMPM in 2014 . The impact to a plan would depend on the number of lives covered. *(Source*: *Id*. p. 133.)

[5] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010. Pursuant to the PPACA, all health plans, including those with grandfathered status are required to provide the following as of September 23, 2010: 1) No lifetime limits on coverage, 2) No rescissions of coverage when individual gets sick or has previously made an unintentional error on an application, and 3) Extension of parents' coverage to young adults until age 26. (www.healthcare.gov)

[6] According to the PPACA, compared to the plans' policies as of March 23, 2010, grandfathered plans who make any of the following changes within a certain margin may lose their grandfathered status: 1) Significantly cut or reduce benefits, 2) Raise co-insurance charges, 3) Significantly raise co-payment charges, 4) Significantly raise

Lastly, the bill 1) removes the requirement that breast magnetic resonance imaging (MRI) be covered under the same circumstances as an ultrasound screening, and 2) removes reference to the American College of Radiology guidelines. These changes do not result in a fiscal impact.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

In addition, the federal health care reform act requires that, effective January 1, 2014, all states must establish a health benefit exchange, which will offer qualified health plans that must include a federally defined essential health benefits package (EHB)[7]. The federal government is allowing states to choose a benchmark plan[8] to serve as the EHB until 2016 when the federal government is anticipated to revisit the EHB.

While states are allowed to mandate benefits in excess of the EHB, the federal law requires the state to pay the cost of any such additional mandated benefits for **all plans** sold in the exchange[9]. The extent of these costs will ultimately depend on the mandates included in the federal

deductibles, 5) Significantly lower employer contributions, and 5) Add or tighten annual limits on what insurer pays. (www.healthcare.gov)

[7] EHB requires coverage in 10 categories. In addition, Section 2711 of the Public Service Act prohibits annual dollar limits or lifetime maximums on EHBs.

[8] The state may choose one of the three largest plans by enrollment in one of the following categories to serve as the benchmark plan: 1) small group, 2) state employee health plans, 3) federal employee health plans, or 4) the largest HMO plan offered in the state's commercial market. If the state does not select one of the aforementioned options, the default plan will be the small group plan with the largest enrollment in the state. (*Source*: Dept. of Health and Human Services. *Essential Health Benefits: HHS Informational Bulletin Fact Sheet* (December 16, 2011)).

[9] As of December 2011, Connecticut had 32 mandated health benefits in law. Maryland has the most, with 35 and Indiana has the least with 6. (*Source:* The Blue Cross/Blue Shield Association. *State Legislative Healthcare and Insurance Issues 2011*. Prepared by: Susan S. Laudicina, Joan M. Gardner, Kim Holland. As reported by NCSL, http://www.ncsl.org/issues-research/health/state-ins-mandates-and-aca-essential-benefits.aspx. Accessed 3/2/12.)

essential benefit package, which have not yet been determined. If the benchmark plan chosen by the state to serve as the EHB includes all state health mandates there is no additional cost to the state. However, if the benchmark plan does not include certain state mandated health benefits the state would be responsible for the cost of those additional mandated benefits. Lastly, state mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB for 2014-2015 unless they are already part of the benchmark plan[10].

[10] *Source*: Dept. of Health and Human Services. *Frequently Asked Questions on Essential Health Benefits Bulletin* (February 21, 2012).

OLR Bill Analysis

sSB 97

AN ACT CONCERNING BREAST CANCER SCREENING.

SUMMARY:

This bill prohibits certain health insurance policies from imposing out-of-pocket expenses (e.g., coinsurance, copayment, or deductible) on breast ultrasound screening. But this prohibition does not apply to high deductible health plans designed to be compatible with federally qualified health savings accounts. By law, the policies must cover breast ultrasound screening if a:

1. mammogram shows heterogeneous or dense breast tissue based on the American College of Radiology's Breast Imaging Reporting and Database System or

2. woman is considered to be at an increased breast cancer risk because of family history, her own breast cancer history, positive genetic testing, or other indications determined by her physician or advance-practice registered nurse.

The bill also resolves a statutory conflict regarding coverage of breast magnetic resonance imaging (MRI) by removing a requirement in current law that a policy cover a breast MRI under the same circumstances as ultrasound screening (i.e., dense breast tissue or a woman's increased risk of breast cancer). Current law also requires MRI coverage in all circumstances according to guidelines established by the American Cancer Society or the American College of Radiology. This bill removes reference to the American College of Radiology. Thus, it requires policies to cover breast MRI in accordance with American Cancer Society guidelines.

EFFECTIVE DATE: January 1, 2013

APPLICABILITY

The bill applies to individual and group health insurance policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including those provided by HMOs. They also apply to individual policies that cover limited benefit health coverage. (Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.)

BACKGROUND

Related Bill

SB 12, favorably reported by the Insurance and Real Estate Committee on February 21, 2012, resolves the MRI statutory conflict differently than sSB 97 does. SB 12 removes the requirement that certain insurance policies cover MRIs in accordance with guidelines established by the American Cancer Society or the American College of Radiology but continues to require that the policies cover breast MRIs when a mammogram shows dense breast tissue or a woman is at an increased risk of breast cancer.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 16 Nay 4 (02/28/2012)